KENTUCKY MEDICAL ASSISTANCE PROGRAM
Primary Care Centers, Rural Health Clinics, and Federally Qualified Health Centers
Universal Cost Report

Department for Medicaid Services
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Kentucky Medicaid
Universal Cost Report

TABLE OF CONTENTS

CERTIFICATION BY OFFICER OR ADMINISTRATOR

Medicaid Provider No. _____
Period: From _____
To _____

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medical Assistance Program Universal Cost Report for the period ended _____ and that, to the best of my knowledge and belief, they are true, correct and complete statements prepared from the books and records of _____ (Provider Name), in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator

_____
Title

_____
Date

PROVIDER CONTACT AND/OR DESIGNEE

Name: _____

Address: _____

Phone: _____

Fax: _____

E-mail: _____

Corporate owner under name other than PCC or RHC:
(i.e., name of hospital that owns entity) _____

Corporate Contact: _____

KENTUCKY MEDICAL ASSISTANCE PROGRAM
Primary Care Centers, Rural Health Clinics, and Federally Qualified Health Centers
Universal Cost Report

For

_____

(Provider Name)

_____

(Provider Number)

_____

(Address)

_____

(City)

_____

(Phone)

_____

(Fax)

_____

(E-mail)

For the Period Beginning _____

and Ending _____

STATISTICAL AND OTHER DATA

Medicaid Provider No _____
Period: From _____
To _____

General Information

1. Provider Name _____ Date Submitted _____

Date facility licensed as primary care center or rural health clinic _____

Name of Chief Administrative Officer _____

Title _____ Telephone Number _____

Type Of Control

2.

(a) **Voluntary Non Profit**	(b) **Proprietary**	(c) **Government**
( ) Church	( ) Individual	( ) State
( ) Other - (Specify) _____	( ) Partnership	( ) County
	( ) Corporation	( ) City
	( ) Other - (Specify) _____	( ) Other - (Specify) _____

Name of Governing Board _____

Address _____

Name of Chairman of Governing Board _____

Statistical Data

3. Number of Visits or Encounters:

		Number	Percent
Title XIX Covered Visits	(a)	_____	_____
Title XVIII Covered Visits	(b)	_____	_____
All Other Visits	(c)	_____	_____
Total Visits	(d)	_____	_____

ADJUSTMENT AND RECLASSIFICATION OF OPERATING EXPENSES

Schedule A

Medicaid Provider No. _____

Period From _____

To _____

	COST CENTERS	Salaries	Other	Total	Adjustments	Reclassifications	Net (1) Expenses
		1	2	3	4	5	6
	General Service Cost Centers:						
1.	Depreciation						
2.	Property & Plant Operation						
3.	Housekeeping & Maintenance						
4.	Employee Benefits						
5.	Employee Education & Training						
6.	Administration & General						
7.	Central Services & Supplies						
8.	Medical Records						
9.	Patient Transportation						
10.	Outreach						
11.	Health Education Services						
12.	Social Services						
13.	Nutritional Counseling						
14.	Family Planning Counseling						
15.	Clinical Pharmacology						
16.	Other (Specify)						
17.	Other (Specify)						
	Direct Service Cost Centers:						
18. a.	Medical & Nursing Services						
b.	Screening (EPSDT)						
c.	Home Health						
d.	Nurse Midwifery						
e.	Audiology						
f.	Other (Specify)						
g.	Other (Specify)						
19.	Laboratory						
20.	Radiology						
21.	Pharmacy						
22.	Dental Services						
23.	Optometry Services						
24.	Other (Specify)						
25.	Other (Specify)						
	Other Non-Reimbursable Cost Centers:						
26.	Research						
27.	Other (Specify)						
28.	Other (Specify)						
29.	**TOTAL EXPENSES**					-0-	

(1) Transfer amounts in Column 6 to Schedule B, Column 1.

Schedule A-1

ADJUSTMENTS TO EXPENSES

Medicaid Provider No. _____
Period From _____
To _____

Description	(1) Basis For Adjustment	Amount (2) Increase (Decrease)	Schedule A Line # to be Increased Or Decreased
	1	2	3
1. Investment Income on Comingled Restricted and Unrestricted Funds			
2. Trade Quantity and Time discounts On Purchase			
3. Rebates and Refunds of Expnese			
4. Telephone Service (Pay Stations, etc.)			
5. Parking Lot			
6. Sale of Scrap, Waste, etc.			
7. Rental of Living Quarters to Employees and Others			
8. Rental of Facility Space			
9. Sale of Medical Supplies to Other Than Patients			
10. Sale of Medical records and Abstracts			
11. Vending Machine Concessions			
12. Finance or Penalty Charges			
13. Fund Raising Expenses			
14. Grants, Gifts and Income Designaed by Donor for Specific Expenses, Net of Fund Raising Expenses			
15. Reimbursement From Employees for Educatitonal Costs			
16. Recovery of Insured Loss			
17. Depreciation			
18. Adjustment Resulting From Transactions With Related Organizations			
19. Gains and Losses on Disposals of Capital Assets			
20. Other (Specify)			
21. Other (Specify)			
22. Other (Specify)			
23. **TOTAL ADJUSTMENTS**		$ -	

(1) (A) = Costs, (B) = Revenues
(2) Transfer Amounts in Column 2 to Schedule A, Column 4

ADJUSTMENTS TO EXPENSES

Medicaid Provider No. _____
Period From _____
To _____

Description	(1) Basis For Adjustment	Amount (2) Increase (Decrease)	Schedule A Line # to be Increased Or Decreased
	1	2	3
24. **SUBTOTAL FROM PAGE 1**		$ -	
25. Other (Specify)			
26. Other (Specify)			
27. Other (Specify)			
28. Other (Specify)			
29. Other (Specify)			
30. Other (Specify)			
31. Other (Specify)			
32. Other (Specify)			
33. Other (Specify)			
34. Other (Specify)			
35. Other (Specify)			
36. Other (Specify)			
37. Other (Specify)			
38. Other (Specify)			
39. Other (Specify)			
40. Other (Specify)			
41. Other (Specify)			
42. Other (Specify)			
43. Other (Specify)			
44. Other (Specify)			
45. Other (Specify)			
46. Other (Specify)			
47. Other (Specify)			
48. Other (Specify)			
49. Other (Specify)			
50. **TOTAL ADJUSTMENTS**		$ -	

(1) (A) = Costs, (B) = Revenues
(2) Transfer Amounts in Column 2 to Schedule A, Column 4

Schedule A-2

RECLASSIFICATION OF EXPENSES

Medicaid Provider No. _____

Period From _____

To _____

Explanation	Increase (1) Cost Center	Line No.	Amount	Decrease (1) Cost Center	Line No.	Amount
	1	2	3	4	5	6
To Reclassify to						
1. Employee Benefits	Empl. Ben.	4.		Admin. & Gen.	6.	
2. Personnel Dept.	Empl. Ben.	4.		Emp. Educ & Trn.	5.	
3. Health Service						
4. Hospitalization Ins.						
5. Workmen's Comp.						
6. Group Ins.						
7. Social Security Taxes						
8. Unemployment Taxes						
9. Pension Plan Costs						
10.						
To Reclassify to						
11. Depreciation	Depreciation	1.		Admin. & Gen.	6.	
12. Property Ins.						
13. Property Interest						
14. Property Taxes						
15. Rent						
16.						
To Reclassify to						
17. Depreciation	Depreciation	1.		Property & Plant Op.	2.	
18.				Housekeep. & Mnt.	3.	
19.						
To Reclassify to						
20. Employee Benefits	Empl. Ben.	4.		Empl. Ed. & Trn.	5.	
21.						
To Reclassify to						
22. Admin. & General	Admin. & Gen.	6.		Cen. Sys. & Sup.	7.	
23.				Med. Recs.	8.	
24.				Pat. Trans.	9.	
25.						
26.						
27.						
To Reclassify to						
28. Outreach	Outreach	10.		Health Ed.	11.	
29.						
To Reclassify to						
30. Social Services	Soc. Serv.	12.		Nutr. Cous.	13.	
31.				Fam. Plan.	14.	
32.				Clin. Pharm.	15.	
33.						
34.						
35.						
36						
37.						
38.						
39.						
40. SUBTOTAL						

(1) Transfer Amounts in Columns 3 & 6 to Schedule A, Column 5

Schedule A-2

RECLASSIFICATION OF EXPENSES

Medicaid Provider No. _____
Period From _____
To _____

	Explanation	Increase (1) Cost Center 1	Line No. 2	Amount 3	Decrease (1) Cost Center 4	Line No. 5	Amount 6
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.							
32.							
33.							
34.							
35.							
36.							
37.							
38.							
39.							
40.							
41.							
42.							
43.							
44.							
45.							
46.							
47.	TOTAL						

(1) Transfer Amounts in columns 3 & 6 to Schedule A, Column 5

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

Schedule A-3

Medicaid Provider No. _____

Period From _____

To _____

A. In The Amount Of Costs To Be Reimbursed By The KMAP Program, Are Any Costs Included Which Are The Result Of Transactions With Related Parties?

_____ YES _____ NO

IF YES: Complete Parts B and C.

B. Costs Incurred And Adjustments Required As Result Of Transactions With Related Organizations:

	Amount Reported On Schedule A					
	Line No.	Cost Center	Expense Item	Amount Reported	Amount Allowable	Adjustment (4 - 5)
	1	2	3	4	5	6
1.						
2.						
3.						
4.						
5.	TOTAL					

C. Interrelationship Of Provider To Related Organizations:

	Provider			Related Organization		
	(1) Code	Name	% Ownership	Name	% Ownership	Type Of Business
	1	2	3	4	5	6
1.						
2.						
3.						
4.						

(1) Use the following codes to indicate the interrelationship of the provider with related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organizations and in provider.

B. Corporation, partnership or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership or other organization.

D. Director, officer, administrator, or key person of provider of such person has financial interest in related organization

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization ore relative of such person has financial interest in provider.

G. Other (financial or non-financial). Specify.

SCHEDULE OF STAFFING COSTS

Schedule A-4

Medicaid Provider No. _____

Period From _____

To _____

	% of Business Ownsh.	Number of Staff FTEs	Annual Hours	Compensation	Fringe Benefits	Payroll Taxes	Total Cost	Total Visits	Cost per FTE	Cost per Hour	Cost per Visit
		1	2	3	4	5	6	7	8	9	10
Administrative Staff											
1. Chief Administrative Staff								XXXXXXX			XXXXXXX
2. Chief Financial Officer								XXXXXXX			XXXXXXX
3. Medical Director								XXXXXXX			XXXXXXX
4. Other Administrative Staff								XXXXXXX			XXXXXXX
5. Total Administrative Staff								XXXXXXX			XXXXXXX
Medical Staff											
6. Physicians											
7. Physician Assistants											
8. Nurse Practitioners											
9. Nurse Midwives											
10. Dentists											
11. Licensed Practical Nurses								XXXXXXX			XXXXXXX
12. Aides								XXXXXXX			XXXXXXX
13. Registered Nurses								XXXXXXX			XXXXXXX
14. Other: Visiting Nurse								XXXXXXX			XXXXXXX
15. Total Medical Staff								XXXXXXX			XXXXXXX
Other Staff											
16. Radiologists								XXXXXXX			XXXXXXX
17. Radiology Technicians								XXXXXXX			XXXXXXX
18. Pathologists								XXXXXXX			XXXXXXX
19. Pathology Technicians								XXXXXXX			XXXXXXX
20. Pharmacists								XXXXXXX			XXXXXXX
21. Clinical Pharmacists								XXXXXXX			XXXXXXX
22. Optometrists								XXXXXXX			XXXXXXX
23. Other: Clinical Psychologist								XXXXXXX			XXXXXXX
24. Other: Clinical Social Worker								XXXXXXX			XXXXXXX
25. Phys. Srvcs Under Agreement								XXXXXXX			XXXXXXX
26. Total Other Staff								XXXXXXX			XXXXXXX
26. **TOTAL**											

SUMMARY OF PURCHASED SERVICES

Schedule A-4-1

Medicaid Provider No. _____

Period From _____

To _____

Name	Service Provided	Cost Center	Units of Service	Fee per Unit	Amount
Administrative Services:					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
Medical Services:					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
Other Services:					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25. **TOTAL**					

DEPRECIATION QUESTIONNAIRE

Schedule A-5

Medicaid Provider No. _____

Period From _____

To _____

1. Was Depreciation Included In Cost Report Calculated On A Straight Line Basis?

_____ YES _____ NO

2. Is Depreciation Funded?

_____ YES _____ NO

If YES: What Basis? _____

Where Recorded? _____

Balance In Fund At End Of Period $ _____

Earnings Of Fund During Period $ _____

3. Were There Any Gains Or Losses On Disposals Of Capital Assets During This Period?

_____ YES _____ NO

If YES: Were The Effects Of Those Gains And Losses Excluded From Expenses On Schedule

_____ YES _____ NO

If NO: Where Included?

Cost Center _____ Amount $ _____

Schedule A-6

GRANTS, GIFTS AND ENDOWMENT FUNDS

Medicaid Provider No. _____
Period From _____
To _____

Source	Specified (1) Purpose	CHANGES IN FUND BALANCE: Beginning Balance 1	Received 2	Expended 3	Ending (2) Balance 4
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10. Subtotal - Restricted					
11. Subtotal - Unrestricted					
12. **TOTAL**					

DONATED ASSETS

	Source	Description	Cost Basis
1.			
2.			
3.			
4.			
5.			

(1) Identify Restricted Purpose of Fund, if None, IndicatedUnrestricted.
(2) Column 1 + Column 2 - Column 3.
(3) Transfer Amounts from Schedule E-1, Line F-1.

Schedule B

COST ALLOCATION

Medicaid Provider No. _____
Period From _____
To _____

Cost Center	Net (1) Expense	Depreciation	Employee Benefits	Sub-Total	Admin. & General	Outreach	Social Services	Other ( )	Other ( )	Other ( )	Total (2)
	1	2	3	4	5	6	7	8	9	10	11
General Service Cost Centers:											
1. Depreciation											
2. Employee Benefits											
3. Administration & General											
4. Outreach											
5. Social Services											
6. Other											
7. Other											
8. Other											
Direct Service Cost Centers:											
9. Medical & Nursing Services (3)						XXXXXX	XXXXXX				
10. Laboratory						XXXXXX	XXXXXX				
11. Radiology						XXXXXX	XXXXXX				
12. Pharmacy							XXXXXX				
13. Dental Services						XXXXXX	XXXXXX				
14. Optometry Services						XXXXXX	XXXXXX				
15. Other (Specify)						XXXXXX	XXXXXX				
16. Other (Specify)						XXXXXX	XXXXXX				
17. Other											
Other Non-Reimbursable Cost Centers:											
18. Research						XXXXXX	XXXXXX				
19. Other (Specify)						XXXXXX	XXXXXX				
20. Other (Specify)						XXXXXX	XXXXXX				
21. Other						XXXXXX	XXXXXX				
22. **Total Expenses**											

(1) Transfer amounts to Column 1 from Schedule A, Column 6.
(2) Transfer amounts in Column 11 to Schedule C, Column 4.
(3) Transfer amounts in Column 1, Line 9, from Schedule A, Column 6, Line 18a, thru 18g.

Schedule B-1

COST ALLOCATION STATISTICS

Medicaid Provider No. _____
Period From _____
To _____

Cost Center	Depreciation (Sq. Ft.)	Employee Benefits (Gross Sal.)	Admin. & General (Accum. Cost)	Outreach (# Visits)	Social Services (% Assigned)	Other ( )	Other ( )	Other ( )
	2	3	5	6	7	8	9	10
Direct Service Cost Centers:								
9. Medical & Nursing Services								
10. Laboratory				XXXXXX	XXXXXX			
11. Radiology				XXXXXX	XXXXXX			
12. Pharmacy				XXXXXX	XXXXXX			
13. Dental Services					XXXXXX			
14. Optometry Services				XXXXXX	XXXXXX			
15. Other (Specify)				XXXXXX	XXXXXX			
16. Other (Specify)				XXXXXX	XXXXXX			
17. Other				XXXXXX	XXXXXX			
Other Non-Reimbursable Cost Centers:								
18. Research			#	XXXXXX	XXXXXX			
19. Other (Specify)				XXXXXX	XXXXXX			
20. Other (Specify)				XXXXXX	XXXXXX			
21. Other				XXXXXX	XXXXXX			
22. Total Statistic								
23. Cost to be Allocated (1)								
24. Unit Cost Multiplier (2)								

(1) Transfer Amounts From Schedule B, Column 1, Lines 1 thru 8.
(2) Line 23 - Line 22.

APPORTIONMENT OF DEPARTMENTAL COSTS TO TITLE XIX

Schedule C

Medicaid Provider No. _____

FYE: _____

	Cost Centers	Units Of Service	Number Of Units of Service		Title XIX Utilization	Total Departmental Cost	Title XIX Departmental Cost
			Title XIX	Total			
			1	2	3	4	5
1.	Medical And Nursing Services	Visits					
2.	Laboratory	Procedures					
3.	Radiology	Procedures					
4.	Pharmacy	Prescriptions					
5.	Dental Services	Visits					
6.	Optometry Services	Visits					
7.	Other (Specify)						
8.	Other (Specify)						
9.	Other						
10.	**TOTAL**						

SUMMARY STATEMENT OF REVENUES AND EXPENSES

Schedule E-1

Medicaid Provider No. _____

Period: From _____

To _____

A. **Patient Revenues**			
1. Title XIX	$ -		
2. Other (Specify)_____			
_____			
_____			
3. Total Patient Revenues		$ -	
B. **Bad Debts and Allowances**			
1. Allowance for Bad Debts			
2. Other (Specify)_____			
_____			
_____			
3. Total Allowances and Bad Debts		$ -	
C. **Net Patient Revenues**			$ -
D. **Less - Total Operating Expenses**			$ -
E. **Net Income From Service to Patients**			$ -
F. **Other Revenues**			
1. Contributions, donations, etc.,			
--Restricted	$ -		
--Unrestricted			
2. Interest Income			
--Restricted			
--Unrestricted			
3. Rental Income			
4. Other Investment Income			
5. Revenue From Coffee Shop/Canteen, Vending Machines			
6. Parking Lot			
7. Other (Specify)_____			
_____			
_____			
8. Total Other Revenues		$ -	
G. **Other Expenses**			
1. Other (Specify)_____	$ -		
_____			
_____			
2. Total Other Expenses		$ -	
H. **Total Other Revenues and Expenses**			$ -
I. **Net Income (Loss) For the Period**			$ -

STATEMENT OF CHANGES IN FUND BALANCE

Schedule E-2

Medicaid Provider No. _____

Period: From _____

To _____

Fund Balance as of _____		$ -
Additions		
_____	$ -	
_____	_____	
_____	_____	$ -
Total Additions		
Deductions		
_____	$ -	
_____	_____	
_____	_____	
Total Deductions		$ -
Fund Balance as of		$ -

BALANCE SHEET
(Prior Period)

Medicaid Provider No. _____ FYE: _____

ASSETS

A. **CURRENT ASSETS**

1.	Cash on Hand and in Bank		$ -
2.	Short-Term Investments		
3.	Accounts Receivable	$ -	
4.	Notes Receivable		
5.	Less: Allowance for Uncollectible Accounts and Notes Receivable		
6.	Inventories		
7.	Prepaid Expenses		
8.	Other Current Assets (Specify)		
9.	TOTAL CURRENT ASSETS		$ -

B. **PROPERTY, PLANT AND EQUIPMENT**

		COST	ACCUM DEPR.	BOOK VALUE
1.	Land	$ -		$ -
2.	Buildings		$ -	
3.	Leasehold Imp.			
4.	Movable Equipment			
5.	Motor Vehicles			
6.	Other Fixed Assets (Specify)			
7.	TOTAL PROPERTY, PLANT AND EQUIPMENT			$ -

C. **OTHER ASSETS (if any)**

1.	Deposits		$ -
2.	Long-Term Investments		
3.	Special Funds		
4.	Other (Specify)		
5.	TOTAL OTHER ASSETS		$ -

TOTAL ASSETS $ -

BALANCE SHEET
(Current Period)

Medicaid Provider No. _____ FYE: _____

ASSETS

A. **CURRENT ASSETS**

1. Cash on Hand and in Bank			$ -
2. Short-Term Investments			
3. Accounts Receivable	$ -		
4. Notes Receivable			
5. Less: Allowance for Uncollectible Accounts and Notes Receivable			
6. Inventories			
7. Prepaid Expenses			
8. Other Current Assets (Specify)			
9. TOTAL CURRENT ASSETS			$ -

B. **PROPERTY, PLANT AND EQUIPMENT**

	COST	ACCUM DEPR.	BOOK VALUE
1. Land	$ -		$ -
2. Buildings		$ -	
3. Leasehold Imp.			
4. Movable Equipment			
5. Motor Vehicles			
6. Other Fixed Assets (Specify)			
7. TOTAL PROPERTY, PLANT AND EQUIPMENT			$ -

C. **OTHER ASSETS (if any)**

1. Deposits			$ -
2. Long-Term Investments			
3. Special Funds			
4. Other (Specify)			
5. TOTAL OTHER ASSETS			$ -

TOTAL ASSETS $ -

BALANCE SHEET
(Prior Period)

Medicaid Provider No. _____ FYE: _____

LIABILITIES

A. **CURRENT LIABILITIES**

1.	Accounts Payable	$ -
2.	Mortgages Payable within one year	
3.	Notes and Loans Payable one year	
4.	Salaries and Wages Payable	
5.	Payroll Taxes Payable	
6.	Accrued Taxes	
7.	Deferred Income	
8.	Other Current Liabilities (Specify) _____	
	_____	
9.	TOTAL CURRENT LIABILITIES	$ -

B. **LONG-TERM LIABILITIES**

1.	Mortgages Payable Over one year	$ -
2.	Notes Payable Over one year	
3.	Unsecured Loans	
4.	Other Long-term Liabilities (Specify) _____	
	_____	
5.	TOTAL LONG-TERM LIABILITIES	$ -
		$ -

FUND BALANCE

1.	Unrestricted	$ -
2.	Restricted (Specify)_____	
	_____	
3.	Other _____	
	TOTAL FUND BALANCE	$ -

TOTAL LIABILITIES AND FUND BALANCE $ -

BALANCE SHEET
(Current Period)

Medicaid Provider No. _____ FYE: _____

LIABILITIES

A. **CURRENT LIABILITIES**

1.	Accounts Payable	$ -
2.	Mortgages Payable within one year	
3.	Notes and Loans Payable one year	
4.	Salaries and Wages Payable	
5.	Payroll Taxes Payable	
6.	Accrued Taxes	
7.	Deferred Income	
8.	Other Current Liabilities (Specify) _____	
	_____	
9.	TOTAL CURRENT LIABILITIES	$ -

B. **LONG-TERM LIABILITIES**

1.	Mortgages Payable Over one year	$ -
2.	Notes Payable Over one year	
3.	Unsecured Loans	
4.	Other Long-term Liabilities (Specify) _____	
	_____	
5.	TOTAL LONG-TERM LIABILITIES	$ -
		$ -

FUND BALANCE

1.	Unrestricted	$ -
2.	Restricted (Specify)_____	
	_____	
3.	Other _____	
	TOTAL FUND BALANCE	$ -

TOTAL LIABILITIES AND FUND BALANCE $ -